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IN THE

Supreme Court of the United States

JOHN J. KANE REGIONAL CENTERS – GLEN HAZEL,
Petitioner,

v.

SARAH GRAMMER,
Respondent.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Third Circuit

AMICUS CURIAE BRIEF OF AMERICAN ASSOCIATION OF HOMES AND SERVICES FOR THE AGING AND AMERICAN HEALTH CARE ASSOCIATION IN SUPPORT OF PETITION FOR WRIT OF CERTIORARI

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INTEREST OF THE AMICI

The American Association of Homes and Services for the Aging (AAHSA) and American Health Care Association (AHCA) are the nation's largest associations of long term care providers. AHCA represents 11,000 not-for-profit, government operated, and proprietary members, and AAHSA represents 5,700 not-for-profit members. Those members, in turn, serve millions of Americans and their families when those individuals need adult day services, home health, community services, senior housing, assisted living residences, continuing care retirement communities, and skilled nursing care. AHCA has been authorized by its governing board to file an amicus curiae brief in this case. AAHSA has been authorized by its Legal Committee to file an amicus curiae brief in this case.[1]

AHCA and AAHSA advocate for quality health care for frail, elderly, and disabled Americans. They specifically represent the interests of their members on federal and state regulatory issues. The ultimate focus of the Associations and their members is providing quality care to individuals in need, and promoting reasonable public policies that balance economic and regulatory objectives to achieve that end.

The members of AHCA and AAHSA include government operated nursing facilities. Government

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[1] No party made any monetary contribution to this brief and no party's attorney drafted any portion of it. The sole entities who made monetary contributions to this brief are the amici, AAHSA and AHCA. Pursuant to this Court's Rule 37.2(a), AAHSA and AHCA have given timely notice to both parties of amici's intent to file this brief, and both parties have consented.

entities often operate nursing homes as safety net facilities for the most disadvantaged members of their communities. Nationwide, there are 921 government operated nursing facilities, which represent 5.9% of all nursing facilities. They serve over 90,000 Americans. In the Third Circuit, there are 62 government operated nursing facilities. They serve more than 16,000 Americans. States and counties frequently afford these entities sovereign immunity in recognition of the important public purpose that they serve. The protection from liability helps ensure their solvency and the continued availability of services for needy members of the community.

AHCA and AAHSA are interested in this case because the court of appeals has created a federal cause of action under 42 U.S.C. § 1983 for medical malpractice against publicly owned nursing homes. The opinion misapplies this Court's precedents for determining whether a federal right exists under § 1983 and creates a parallel private enforcement regime for claims against publicly owned nursing facilities that contradicts the comprehensive public administrative enforcement scheme Congress adopted.

The result will be increased regulatory confusion and uncertainty, as well as substantial additional expense, for all publicly owned nursing homes that serve Medicare or Medicaid patients. Government-operated nursing homes are sometimes the only facilities who serve the most needy members of society. The broad new range of liability to which the court of appeals has subjected such nursing homes will make it more difficult for them to operate and decrease the number of needy residents that they may serve. These results are hardly in the interest of these vulnerable residents.

ARGUMENT

This brief supports a grant of certiorari on the second question presented by the petition. That question presents a simple but extremely important issue: does a Medicaid statute authorize a private action for damages under 42 U.S.C. § 1983 against a nursing home owned by a state or local governmental agency? While three of the five judges who examined the issue in the instant case thought not, the two who did were members of the court of appeals.

Plaintiff Sarah Grammer brought this action against John J. Kane Regional Centers – Glen Hazel (Kane Center) to recover damages for the death of her mother. Kane Center is a nursing home operated by Allegheny County, Pennsylvania, and hence is entitled to the state's sovereign immunity from common law damage actions. The § 1983 action is a transparent effort to evade that immunity.

I. THE COURT OF APPEALS' HOLDING FEDERALIZES MEDICAL MALPRACTICE CLAIMS AGAINST STATE-RUN NURSING HOMES.

At oral argument before the court of appeals, Grammer's counsel candidly conceded that this case is nothing more than a medical malpractice claim dressed up in § 1983 clothes. His theory is that the alleged violation of 42 U.S.C. § 1396r is negligence per se.

In accepting that theory, the court of appeals committed two fundamental errors. First, it was "not concerned that the provisions relied on by Appellant are phrased in terms of responsibilities imposed on the state or the nursing home," App. 20a, although

this Court has repeatedly held that such responsibilities do not, as a matter of law, give rise to a § 1983 claim for damages. Second, it paid essentially no attention to the public enforcement mechanisms that Congress included in the statute, even though this Court has repeatedly cautioned that such mechanisms argue against a § 1983 claim for damages. Thus, these holdings directly contradict *Gonzaga University v. Doe*, 536 U.S. 273 (2002), and other opinions of this Court discussed in *Gonzaga*.

Medicaid is a Spending Clause statute. As a general rule, damages under § 1983 are not available "when the plaintiff alleges only a deprivation of rights secured by a Spending Clause statute." *Guardians Ass'n v. Civil Service Comm'n*, 463 U.S. 582, 602 n.23 (1983). Unless the spending statute "manifests an 'unambiguous' intent to confer individual rights, federal funding provisions provide no basis for private enforcement by § 1983." *Gonzaga*, 536 U.S. at 280, *quoting Pennhurst State School & Hospital v. Halderman*, 451 U.S. 1 (1981). Only twice in the last 30 years has this Court found such a clear intent, *id.*, and neither of those cases involved claims for damages.

Here, the court of appeals purported to find such rights in the provisions of § 1396r(b), the title of which is "requirements relating to provision of services." That section requires nursing homes to assess their residents and prepare a plan to care for them. It requires nursing homes to provide nursing, rehabilitative and social services to "attain or maintain the highest practicable physical, mental and psychosocial well being of each resident." § 1396r(b)(4). It requires other services such as dental and dietary to "meet the needs" of each resident. *Id.*

All of those requirements, however, are obligations imposed on nursing homes, not rights conferred on patients. "Statutes that focus on the person regulated rather than the individuals protected create 'no implication of an intent to confer rights on a particular class of persons.'" *Alexander v. Sandoval*, 532 U.S. 275, 289 (2001), *quoting California v. Sierra Club*, 451 U.S. 287, 294 (1981). *Accord, Gonzaga*, 536 U.S. at 287, *quoting Sandoval*. The court of appeals simply ignored these principles.

Nothing in § 1396r(b) focuses on the rights of the residents as opposed to the obligations of the nursing home. Each of the subsections of § 1396r(b) directs what a nursing home "must" or "must not" do. That statute is not "'phrased in terms of the persons benefited,'" and hence does not create a private right. *Gonzaga*, 536 U.S. at 284 *quoting Cannon v. University of Chicago*, 441 U.S. 677, 692 n.13 (1979).

This Court has repeatedly held that the imposition of standards of conduct as part of a Spending Clause statute does not create enforceable rights under § 1983:

> [T]his provision is a standard of conduct imposed by the Secretary upon the provider. Violation of this standard is one of many grounds for decertifying the offending institution. The provision creates no 'substantive interest' in the residents vis-à-vis the Secretary.

O'Bannon v. Town Court Nursing Center, 447 U.S. 773, 782 n.13 (1980) (citation omitted).

By contrast, § 1396r(c) does speak in terms of procedural requirements "relating to residents' rights" – *e.g.*, the right to choose a physician, the right to privacy, or the right to file grievances. If Congress

had intended to give residents the right to enforce the substantive requirements of § 1396r(b), it would have used similar rights-creating language.[2] *Bates v. United States*, 522 U.S. 23, 29-30 (1997) (when "Congress includes particular language in one section of a statute but omits it in another section of the same Act, it is generally presumed that Congress acts intentionally and purposely in the disparate inclusion or exclusion").

In argument before the court of appeals, Grammer's counsel was remarkably candid about his desire to federalize medical malpractice claims against nursing homes operated by states and their political subdivisions:[3]

> Q: Let me begin by asking you what I suppose could be construed as a question of legal policy but is not the position that you urged upon us one that would completely federalize malpractice cases that occur in nursing homes that are operated by state and local governments?
>
> A: To some extent, yes.
>
> Q: Well to what extent would it?
>
> A: To the extent that those nursing homes did not participate in the Medicaid program. But once they choose to participate in the federal

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[2] Amici do not mean to suggest that § 1396r(c) does create the right to seek damages under § 1983. As explained at pp. 9-14, *infra*, the administrative enforcement scheme that Congress created for § 1396r violations is clear evidence that Congress did not intend to create such a right.

[3] An audio recording of the argument is available at http://www.ca3.uscourts.gov/oralargument/audio/07-2358GrammervKaneRegionalCenters.wma.

Medicaid program, they're they are bound to abide by the Medicaid regulation.

. . . .

Q: Is your lawsuit here basically one of medical malpractice . . . .?

A: Well, I . . .

Q: . . . against a care giving facility? Isn't that basically what your clients are claiming? That their deceased was not treated properly by the medical center?

A: Yes. Yes, I would agree with that. Although . . . .

Q: Let me finish, counsel, and then you talk. Is there not a remedy in the state courts in the commonwealth for that?

A: No, there is not. If we are not dealing – if we were not dealing with the government actor, which we are in this case, we could certainly bring a common law cause of action for negligence. And in so doing, as we routinely do . . . .

Q: You have a wrongful death, don't you?

A: Yes. Yes.

Q: Okay.

A: As we routinely do in a situation like this, where the defendant home is a Medicaid beneficiary, we rely upon the violations of these federal provisions and the Medicaid Act to serve as a basis for not only the standard of care, which they indisputably do in the field, but also negligence per se for their violation.

> Q: Well, wouldn't that be what your expert witness would testify if you were trying it in the common pleas court? You would bring the whiz bang in from the medical school and he would testify to the jury that what was provided by the defendant here fell below the standard of care that is indicated for this type of patient.
>
> A: Sure. Absolutely.

Federalizing medical malpractice claims against government-owned nursing homes will have consequences for the workload of the federal courts. If § 1396r is held to permit an action under § 1983, the comparable provisions of the Medicare statute, 42 U.S.C. § 1395i-3, would also allow a § 1983 action.

As of March 2009, there were 16,854 residents in government-owned nursing homes in Delaware, New Jersey and Pennsylvania, the states that comprise the Third Circuit, *Nursing Home Compare Website*, March 2009,[4] 84% of whom receive either Medicare or Medicaid benefits. Aon Global, *Long Term Care: 2008 General Liability and Professional Liability Actuarial Analysis* at 11 (May 12, 2008). The average frequency of claims is 10.6 per 1,000 occupied beds. Aon Global, at 8. For the 14,150 Medicare/Medicaid residents in these facilities, therefore, one can expect an additional 150 claims per year just in the Third Circuit. As the baby boomers begin to retire, those numbers will dramatically increase.

The potential for hundreds or thousands of new federal claims every year is strong evidence that

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[4] *See generally* Centers for Medicare and Medicaid Services, Nursing Home Compare, available at http://www.medicare.gov/NHCompare/home.asp.

Congress did not intend § 1396r to confer a private right to seek damages under § 1983. As the Court has recently stressed, federal issues are appropriate for a federal forum "only if federal jurisdiction is consistent with congressional judgment about the sound division of labor between state and federal courts." *Grable & Sons Metal Products, Inc. v. Darue Engineering & Mfg.*, 545 U.S. 308, 313 (2005):

> Expressing concern over the increased volume of federal litigation, and noting the importance of adhering to legislative intent, *Merrill Dow* thought it improbable that Congress, having made no provision for a federal cause of action, would have meant to welcome any state-law tort case implicating federal law solely because the violation of the federal statute is said to create a rebuttable presumption of negligence under state law.

Id. at 319 (internal punctuation omitted). The same is true here.

The field of health care is a "subject of traditional state regulation." *Pegram v. Herdrich*, 530 U.S. 211, 237 (2000). The Court has unanimously held that Congress did not intend to "federalize [medical] malpractice litigation in the name of [ERISA] fiduciary duty." *Id.* at 236. There is no more reason to suppose that Congress had such an intent in enacting § 1396r.

The comprehensive public enforcement provisions in § 1396r(h) are further evidence that Congress did not intend to allow Medicaid nursing home residents to sue under § 1983. *See also* 42 C.F.R. part 488, subpart F (2008) (titled "Enforcement of Compliance for Long-Term Care Facilities with Deficiencies" and setting forth remedies and enforcement procedures

against nursing facilities). Nursing facilities are subject to unannounced, annual surveys to determine their compliance with Medicaid program participation requirements. 42 U.S.C. § 1396r(g)(2)(A). Additional special surveys or more probing extended surveys are also used to assess a nursing facility's compliance with program requirements. 42 U.S.C. §§ 1396r(g)(2)(B), (D). In general, subsections (g) and (h) confer survey and enforcement authority on the states. When a state owns a nursing home, the Secretary of Health and Human Services is responsible for survey and enforcement. §§ 1396r(g)(1)(A), (h)(3).

When program non-compliance is identified during a survey, the remedies available to the state and to the Secretary are essentially identical. In the case of a state-owned nursing home, the Secretary may:

- Terminate the facility's participation in the Medicaid program.
- Deny further Medicaid payments to the nursing home.
- Impose a civil monetary penalty of up to $10,000 a day.
- Appoint temporary management to either close the facility or bring it into compliance.
- Direct a plan of correction for the facility.
- Specify additional remedies.

§§ 1396r(h)(3)(C), (h)(5). *See also* 42 C.F.R. § 488.406(a) (2008) (identifying transfers of residents, facility closures, and directed in-service training as additional remedies that the Secretary may impose).

These comprehensive public enforcement provisions leave no room for any private right of action for damages under § 1983:

> In legislation enacted pursuant to the spending power, the typical remedy for state noncompliance with federally imposed conditions is not a private cause of action for noncompliance but rather action by the Federal Government to terminate funds to the State.

Gonzaga, 536 U.S. at 280, *quoting Halderman*, 451 U.S. at 28.

In *Suter v. Artist M*, 503 U.S. 347 (1992), this Court relied on similar enforcement provisions as evidence that Congress did not intend to confer a private right to sue:

> While these statutory provisions may not provide a comprehensive enforcement mechanism so as to manifest Congress' intent to foreclose remedies under § 1983, they do show that the absence of a remedy to private plaintiffs under § 1983 does not make the "reasonable efforts" clause a dead letter.

503 U.S. at 360-61. *Accord*, *Gonzaga*, 536 U.S. at 289 ("[o]ur conclusion that FERPA's nondisclosure provisions fail to confer enforceable rights is buttressed by the [administrative] mechanism that Congress chose to provide for enforcing those rights"); *Sandoval*, 532 U.S. at 290 ("express provision of one method of enforcing a substantive rule suggests that Congress intended to preclude others").

Here, the Medicaid statute provides a meaningful opportunity for residents or their families to obtain enforcement by the Secretary. Section 1396r(g)(4)

requires the states (or the Secretary) to establish procedures to investigate complaints about the quality of resident care. Section 1396r(g)(1) requires the Secretary to survey state-owned nursing homes on an annual basis to assure compliance with quality of care requirements.

The ability to obtain meaningful relief outside of a § 1983 action for damages is a critical factor in determining Congressional intent. In both of the cases in which this Court has allowed a § 1983 action to enforce a spending condition, the inability of the plaintiff to obtain enforcement action was a key element of the Court's holding. In *Wright v. City of Roanoke Redevelopment & Housing Authority*, 479 U.S. 418 (1987), for example, the Court reasoned that:

- "HUD has the authority to audit, but it does not do so frequently and its own Handbook requires audits only every eight years."
- There are "no other mechanisms provided to enable HUD to effectively oversee the performance" of local housing authorities.
- "The statute does not require and HUD has not provided any formal procedure for tenants to bring to HUD's attention alleged" violations.

479 U.S. at 428. In *Wilder v. Virginia Hosp. Ass'n*, 496 U.S. 498 (1990), the Court held that such a conclusion was "even more appropriate" in the context of that portion of the Medicaid Act that directly conferred a benefit to providers, but provided no administrative remedy.

Gonzaga distinguished both *Wilder* and *Wright* on precisely these grounds. The statute under review in

Gonzaga allowed students to complain of violations; required an investigation if a timely and specific complaint were filed; and authorized administrative sanctions if a violation were proven. 536 U.S. at 289:

> These administrative procedures squarely distinguish this case from *Wright* and *Wilder*, where an aggrieved individual lacked any federal review mechanism, . . . and further counsel against our finding a congressional intent to create individually enforceable private rights.

Id. at 289-90.

The court of appeals' holding raises a serious prospect of judges and juries imposing standards of conduct on publicly owned nursing facilities that are incompatible with what the Secretary has directed. This Court has often recognized that damage claims are a form of regulation that may be incompatible with other federal requirements. *Cipollone v. Liggett Group, Inc.*, 505 U.S 504, 521 (1992) (federal statute preempted common law claims for damages, because "regulation can be as effectively exerted through an award of damages as through some form of preventive relief").

Most of the provisions of § 1396r(b) on which the court of appeals relied are cast in extremely general terms – "the highest practicable physical, mental and psychosocial well-being of each resident." App. 6a-8a. Those are regulatory terms of art, not standards of negligence, and reliance on the administrative mechanisms that Congress established is essential to assure uniform application. It is highly likely that an expert retained by Grammer's counsel would think those provisions require a much different degree of care than the Secretary does.

This raises the unworkable prospect of multiple inconsistent standards of care imposed on the same nursing home. A publicly-owned nursing home must comply with the Secretary's regulations. One expert might conclude that a very different set of requirements was necessary to provide "the highest practicable physical, mental and psychosocial well-being" of a plaintiff. A second expert might want something completely different and a jury would decide. This sort of regulation by litigation threatens the uniform standards that Congress intended to impose nationwide.

Federalizing medical malpractice claims against publicly-owned nursing homes is bad policy and bad law. The court of appeals' opinion directly contradicts this Court's binding precedents on § 1983.

II. THE COURT OF APPEALS' HOLDING IS DEEPLY INTRUSIVE INTO STATE SOVEREIGNTY.

Grammer's counsel was just as candid about sovereign immunity as about federalizing medical malpractice claims against publicly-owned nursing homes. He openly conceded that there was no "remedy in the state courts" because of "sovereign immunity." While Congress may have the power to allow an end-run around a state's sovereign immunity, this Court has repeatedly held that Congress must act in the most unmistakable terms to do so.

This Court has analogized conditions on federal funding to state and local governments to a contract: in "return for federal funds, the States agree to comply with federally imposed conditions." *Halderman*, 451 U.S. at 17. The States cannot knowingly sign on to such conditions if they do not know what

the federal government expects of them. Thus, if "Congress intends to impose a condition on the grant of federal moneys, it must do so unambiguously." *Id.*

That is especially true in the context of waivers of sovereign immunity. If "Congress intends to alter the usual constitutional balance between the States and the Federal Government, it must make its intention unmistakably clear in the language of the statute." *Gonzaga*, 536 U.S. at 286. This rule reflects the Court's traditional "reluctance to trench on the prerogative of state and local educational institutions by subjecting them to private suits for money damages whenever they fail to comply with a federal funding condition." *Id.* n.5 (internal punctuation omitted).

Ever since the adoption of the Eleventh Amendment, this Court has recognized "the fundamental principle of sovereign immunity" that "limits the grant of judicial authority" to federal courts. *Atascadero State Hosp. v. Scanlon*, 473 U.S. 234, 243 n.3 (1985), and cases there cited. That principle reflects the "special and specific position" that states are accorded under our federal system. *Id.* at 242.

AHCA and AAHSA fully understand that reasonable people can differ over whether the best use of scarce public resources is defending damage actions or improving the quality of care in nursing homes. As a sovereign state in a federal system, Pennsylvania has the right to make that decision itself without intrusive oversight from federal courts.

This Court has never held that Medicare or Medicaid confer private rights to seek damages from the states. The one case in which it allowed a private right to sue to enforce a Medicaid mandated requirement was *Wilder*, which allowed health care provid-

ers to seek reasonable rates of payment. It did not allow the provider to seek damages.

If the Court allows this opinion to stand, that will certainly change, at least in the lower federal courts. And the change will occur despite the complete absence of an unambiguous provision in the Medicaid statute authorizing such suits.

CONCLUSION

For these reasons, AAHSA and AHCA respectfully pray that the Court grant Kane Center's petition for certiorari and reverse the judgment of the court of appeals.

Respectfully submitted,

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